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MULTIPLE SCLEROSIS REFERRAL FORM

Patient Name _____ Today's Date_____ ☐ *NEW* Patient ☐ *CURRENT Patient*
DOB _____ Height _____ Weight _____ ☐ Male ☐ Female Preferred Language _____
Best Phone _____ Email _____
Street Address _____ Apt#_____ City _____ State _____ Zip _____
Ship to Patient at: ☐ Home ☐ Physician Office ☐ Work Address _____
Allergies _____
Current Medications including OTC's (*please fax a complete list*) _____

Please Fax Insurance Card(s) both sides
Insured's Name _____
Relation to Patient _____
Primary Insurance _____
ID# _____ Group # _____
Secondary Insurance _____
ID# _____ Group # _____

Ordering Prescriber _____
Office Contact _____
Street Address _____ Suite #_____
City _____ State _____ Zip _____
Tel _____ Fax _____
Email _____
License# _____
NPI# _____

ICD-10 Code ☐ **G35** Multiple Sclerosis Date of Diagnosis: _____ Date of 1st demyelinating event: _____
☐ **Yes** ☐ **No** Previously Treated for this condition? Medications Failed _____
☐ **Yes** ☐ **No** Is Patient currently on therapy? Type/Medication(s)_____
☐ **Yes** ☐ **No** Will Patient stop taking the medication(s) before starting new medication?
If yes, how long should Patient wait before starting new medication? _____
Date of next blood work _____
Type: ☐ Relapsing-Remitting ☐ Primary Progressive ☐ Clinically Isolated Syndrome (CIS)
☐ Progressive-relapsing ☐ Secondary progressive with relapses ☐ Secondary progressive without relapses

PRESCRIPTION

Medication	Directions	Quantity	Refill
☐ Ampyra (dalfampridine)	☐ Take 10mg by mouth twice daily		
☐ Aubagio (teriflunomide)	☐ Take 7mg by mouth once daily ☐ Take 14mg by mouth once daily		
☐ Gilenya (fingolimod)	☐ Take 0.5mg by mouth once daily		
☐ Tecfidera (dimethyl fumarate)	☐ Take 120mg by mouth twice daily for 7 days, then 240mg by mouth twice daily		
	☐ Take 240mg by mouth twice daily _____		
☐ Copaxone (Glatiramer Acetate)	SIG: ☐ Inject 40 mg subcutaneously 3 times weekly ☐ Other _____		
	SIG: ☐ Inject 20 mg subcutaneously once daily ☐ Other _____		

Prescriber's Signature (signature required. NO STAMPS)_____ **Date** _____

My signature certifies that the person named on this form is my patient and that the information provided on this enrollment form is complete and accurate to the best of my knowledge. I certify this therapy to be medically necessary.
My signature authorizes The Pharmacy and its representatives to act as the agent to execute the insurance prior authorization process, assist the above named patient enroll into patient support programs, and appeal on behalf of prescriber and patient in the event of a prior authorization denial.